806 KAR 17:360. Prompt payment of claims.

RELATES TO: KRS 304.17A-005, 304.17A-700, 304.17A-702(1), 304.17A-704, 304.17A-706, 304.17A-708(1), 304.17A-720, 304.17A-722(3), 304.17A-730, 304.17C-090, 304.99-123

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-722(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the commissioner to promulgate reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. KRS 304.17A-722(1) requires the office to promulgate administrative regulations establishing reporting requirements regarding the prompt payment of claims by insurers offering health benefit plans. This administrative regulation establishes requirements for insurers offering health benefit plans and insurers offering limited health service benefit plans for the provision of dental-only benefits.

Section 1. Definition. (1) "Health care clearinghouse" means an entity that converts health care transactions into standardized formats and forwards them to an insurer.

Section 2. Requirements. (1) An attachment subject to the requirements of KRS 304.17A-706(2) shall be a standardized health claim attachment prescribed by 806 KAR 17:370.

(2) Pursuant to KRS 304.17A-704(4), an insurer response to a claim status inquiry by a provider shall either:

(a) Advise of no record of receiving the claim; or

(b) Provide the date the claim was received by an insurer, its agent, or designee, an insurer reference number for the claim, and one (1) of the following dated actions:

1. Claim is in process, but has not had a determination of denial, payment, contest, or suspension by the insurer;

2. Claim denial, in whole or in part, and reason for denial;

3. Determination to pay claim, in whole or in part;

4. Claim suspension, in whole or in part, and reason for suspension; or

5. Claim contest, in whole or in part, and reason for contest.

Section 3. Claim Payment Time Frame. (1) The payment date of a claim shall be:

(a) The posting date of an electronic payment to a provider account;

(b) The postmark date of a nonelectronic payment mailed to a provider; or

(c) The documented date of nonmailed delivery of a nonelectronic payment received by a provider.

(2) An insurer, its agent, or designee shall be required, as part of the acknowledgment process in accordance with KRS 304.17A-704(2) to notify a provider, its billing agent, or designee that submitted the claim, of an attachment that is missing or in error, if required pursuant to KRS 304.17A-706(2) or 304.17A-720.

(3) Except for a claim involving an organ transplant, an insurer shall be in compliance with KRS 304.17A-702(1) if a clean claim is paid within:

(a) Thirty (30) days of receipt of the claim; or

(b) Three (3) business days of the check date if the check issued for payment of the claim is dated on the 28th, 29th, or 30th day after the claim is received.

(4) An insurer shall be in compliance with KRS 304.17A-702(1) for a clean claim involving an organ transplant if the claim is paid within:

(a) Sixty (60) days of receipt of the claim; or

(b) Three (3) business days of the check date if the check issued for payment of the claim is dated on the 58th, 59th, or 60th day after the claim is received.

(5) The claim payment time frame of KRS 304.17A-702(1) shall:

(a) Include the time a claim is with a health care clearinghouse acting on behalf of an insurer; and

(b) Not include the time a claim is with a health care clearinghouse acting on behalf of a provider.

Section 4. Payment of Interest. (1) The method used to calculate an interest payment required by:

(a) KRS 304.17A-730(1) shall yield an amount not less than the result obtained by dividing the total number of days that a claim remains unpaid after the date payment was due by 365;

(b) Multiplying that quotient by the applicable interest rate established under KRS 304.17A-730(1); and

(c) Multiplying that product by the unpaid amount of the claim owed.

(2) An interest payment shall identify the claim for which it is paid by including the following information:

(a) Name of covered person;

(b) Covered person's insurer identification number;

(c) Name of provider;

(d) Date of service;

(e) Amount of interest paid; and

(f) Insurer reference number for the claim.

(3) Except for nonpayment of interest by a limited health service benefit plan for the provision of dental-only benefits as established under KRS 304.17C-090(3), an insurer shall pay the interest required by KRS 304.17A-730 within thirty (30) days after the date a claim is paid.

(4) An insurer shall not be required to pay interest on corrected payments made in accordance with KRS 304.17A-708(1).

Section 5. Contested Claims. (1) An insurer may contest a clean claim, pursuant to KRS 304.17A-706(1)(a), if an insurer, its agent, or designee has reasonable documented grounds, including:

(a) A covered person has notified the insurer that he has:

1. Another payment source; or

2. A preexisting condition;

(b) A provider has notified the insurer that a covered person has:

1. Another payment source; or

2. A preexisting condition;

(c) The insurer possesses file material establishing that:

1. Another insurer may be primarily responsible for the claim; or

2. A preexisting condition exists;

(d) A health claim attachment indicates another payment source; or

(e) A billing instrument identifies another payment source or a preexisting condition.

(2) An insurer in possession of the documentation listed in subsection (1) of this section shall provide this information to a provider upon request.

Section 6. An insurer offering a limited health service benefit plan for the provision of dental-only benefits, its agent or designee shall be subject to the requirements established under this administrative regulation except for a requirement as established under Section 3(4) of this administrative regulation and KRS 304.17C-090.

Section 7. Insurer Offering a Health Benefit Plan Reporting Requirements. (1) Within the time frames established in KRS 304.17A-722(3), an insurer offering a health benefit plan shall submit to the department, on a calendar quarter basis, a report on the prompt payment of claims.

(2) If an insurer is unable to meet a time frame for reporting on the prompt payment of claims as established in subsection (1) of this section because of unforeseen computer system problems, an extension of time may be granted upon written request to the commissioner.

(3) The report required pursuant to subsection (1) of this section shall contain the information and data elements, as applicable, in the electronic format as prescribed by the Prompt Payment Reporting Manual, DIPR-PPR1.

(4) A reporting insurer shall update any information included within the report later determined to be inaccurate.

Section 8. Insurer Offering a Limited Health Service Benefit Plan Reporting Requirements. An insurer offering a limited health service benefit plan for the provision of dental-only benefits shall:

(1) Annually, no later than June 30 of each year, submit a report to the office on the prompt payment of claims as established under KRS 304.17C-090(2); and

(2) Except for Section 7(1) of this administrative regulation, be subject to the requirements of an insurer offering a health benefit plan as established in this administrative regulation.

Section 9. Incorporation by Reference. (1) "Prompt Payment Reporting Manual, DIPR-PPR1",7/2018, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. This material is also available on the department's Web site: www.insurance.ky.gov. (28 Ky.R. 1021; 1435; 1649; eff. 1-14-2002; 29 Ky.R. 1390; 1808; eff. 1-16-2003; 32 Ky.R. 969; 1398; eff. 3-3-2006; 35 Ky.R. 411; 823; eff. 10-31-2008; 45 Ky.R. 470; eff. 11-2-2018.)